By: Representative Moody

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 1110
(As Passed the House)

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE MEDICAID REIMBURSEMENT FOR SERVICES PROVIDED BY THE
3 STATE DEPARTMENT OF REHABILITATION SERVICES FOR THE CARE AND
4 REHABILITATION OF PERSONS WITH SPINAL CORD INJURIES OR TRAUMATIC
5 BRAIN INJURIES, AS ALLOWED UNDER FEDERAL WAIVERS, USING FUNDS
6 APPROPRIATED TO THE DEPARTMENT FROM THE SPINAL CORD AND HEAD
7 INJURY TRUST FUND AND USED TO MATCH FEDERAL FUNDS; AND FOR RELATED
8 PURPOSES.

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

10 SECTION 1. Section 43-13-117, Mississippi Code of 1972, is
11 amended as follows:

12 43-13-117. Medical assistance as authorized by this article
13 shall include payment of part or all of the costs, at the
14 discretion of the division or its successor, with approval of the
15 Governor, of the following types of care and services rendered to
16 eligible applicants who shall have been determined to be eligible
17 for such care and services, within the limits of state
18 appropriations and federal matching funds:

19 (1) Inpatient hospital services.

20 (a) The division shall allow thirty (30) days of
21 inpatient hospital care annually for all Medicaid recipients;
22 however, before any recipient will be allowed more than fifteen
23 (15) days of inpatient hospital care in any one (1) year, he must
24 obtain prior approval therefor from the division. The division
25 shall be authorized to allow unlimited days in disproportionate
26 hospitals as defined by the division for eligible infants under
27 the age of six (6) years.

28 (b) From and after July 1, 1994, the Executive Director
29 of the Division of Medicaid shall amend the Mississippi Title XIX
30 Inpatient Hospital Reimbursement Plan to remove the occupancy rate

31 penalty from the calculation of the Medicaid Capital Cost
32 Component utilized to determine total hospital costs allocated to
33 the Medicaid Program.
34 (2) Outpatient hospital services. Provided that where the
35 same services are reimbursed as clinic services, the division may
36 revise the rate or methodology of outpatient reimbursement to
37 maintain consistency, efficiency, economy and quality of care.
38 (3) Laboratory and X-ray services.
39 (4) Nursing facility services.
40 (a) The division shall make full payment to nursing
41 facilities for each day, not exceeding thirty-six (36) days per
42 year, that a patient is absent from the facility on home leave.
43 However, before payment may be made for more than eighteen (18)
44 home leave days in a year for a patient, the patient must have
45 written authorization from a physician stating that the patient is
46 physically and mentally able to be away from the facility on home
47 leave. Such authorization must be filed with the division before
48 it will be effective and the authorization shall be effective for
49 three (3) months from the date it is received by the division,
50 unless it is revoked earlier by the physician because of a change
51 in the condition of the patient.
52 (b) Repealed.
53 (c) From and after July 1, 1997, all state-owned
54 nursing facilities shall be reimbursed on a full reasonable costs
55 basis. From and after July 1, 1997, payments by the division to
56 nursing facilities for return on equity capital shall be made at
57 the rate paid under Medicare (Title XVIII of the Social Security
58 Act), but shall be no less than seven and one-half percent (7.5%)
59 nor greater than ten percent (10%).
60 (d) A Review Board for nursing facilities is
61 established to conduct reviews of the Division of Medicaid's
62 decision in the areas set forth below:
63 (i) Review shall be heard in the following areas:
64 (A) Matters relating to cost reports
65 including, but not limited to, allowable costs and cost
66 adjustments resulting from desk reviews and audits.
67 (B) Matters relating to the Minimum Data Set
68 Plus (MDS +) or successor assessment formats including but not

69 limited to audits, classifications and submissions.

70 (ii) The Review Board shall be composed of six (6)
71 members, three (3) having expertise in one (1) of the two (2)
72 areas set forth above and three (3) having expertise in the other
73 area set forth above. Each panel of three (3) shall only review
74 appeals arising in its area of expertise. The members shall be
75 appointed as follows:

76 (A) In each of the areas of expertise defined
77 under subparagraphs (i)(A) and (i)(B), the Executive Director of
78 the Division of Medicaid shall appoint one (1) person chosen from
79 the private sector nursing home industry in the state, which may
80 include independent accountants and consultants serving the
81 industry;

82 (B) In each of the areas of expertise defined
83 under subparagraphs (i)(A) and (i)(B), the Executive Director of
84 the Division of Medicaid shall appoint one (1) person who is
85 employed by the state who does not participate directly in desk
86 reviews or audits of nursing facilities in the two (2) areas of
87 review;

88 (C) The two (2) members appointed by the
89 Executive Director of the Division of Medicaid in each area of
90 expertise shall appoint a third member in the same area of
91 expertise.

92 In the event of a conflict of interest on the part of any
93 Review Board members, the Executive Director of the Division of
94 Medicaid or the other two (2) panel members, as applicable, shall
95 appoint a substitute member for conducting a specific review.

96 (iii) The Review Board panels shall have the power
97 to preserve and enforce order during hearings; to issue subpoenas;
98 to administer oaths; to compel attendance and testimony of
99 witnesses; or to compel the production of books, papers, documents
100 and other evidence; or the taking of depositions before any
101 designated individual competent to administer oaths; to examine
102 witnesses; and to do all things conformable to law that may be

103 necessary to enable it effectively to discharge its duties. The
104 Review Board panels may appoint such person or persons as they
105 shall deem proper to execute and return process in connection
106 therewith.
107 (iv) The Review Board shall promulgate, publish
108 and disseminate to nursing facility providers rules of procedure
109 for the efficient conduct of proceedings, subject to the approval
110 of the Executive Director of the Division of Medicaid and in
111 accordance with federal and state administrative hearing laws and
112 regulations.
113 (v) Proceedings of the Review Board shall be of
114 record.
115 (vi) Appeals to the Review Board shall be in
116 writing and shall set out the issues, a statement of alleged facts
117 and reasons supporting the provider's position. Relevant
118 documents may also be attached. The appeal shall be filed within
119 thirty (30) days from the date the provider is notified of the
120 action being appealed or, if informal review procedures are taken,
121 as provided by administrative regulations of the Division of
122 Medicaid, within thirty (30) days after a decision has been
123 rendered through informal hearing procedures.
124 (vii) The provider shall be notified of the
125 hearing date by certified mail within thirty (30) days from the
126 date the Division of Medicaid receives the request for appeal.
127 Notification of the hearing date shall in no event be less than
128 thirty (30) days before the scheduled hearing date. The appeal
129 may be heard on shorter notice by written agreement between the
130 provider and the Division of Medicaid.
131 (viii) Within thirty (30) days from the date of
132 the hearing, the Review Board panel shall render a written
133 recommendation to the Executive Director of the Division of
134 Medicaid setting forth the issues, findings of fact and applicable
135 law, regulations or provisions.
136 (ix) The Executive Director of the Division of

137 Medicaid shall, upon review of the recommendation, the proceedings
138 and the record, prepare a written decision which shall be mailed
139 to the nursing facility provider no later than twenty (20) days
140 after the submission of the recommendation by the panel. The
141 decision of the executive director is final, subject only to
142 judicial review.
143 (x) Appeals from a final decision shall be made to
144 the Chancery Court of Hinds County. The appeal shall be filed
145 with the court within thirty (30) days from the date the decision
146 of the Executive Director of the Division of Medicaid becomes
147 final.
148 (xi) The action of the Division of Medicaid under
149 review shall be stayed until all administrative proceedings have
150 been exhausted.
151 (xii) Appeals by nursing facility providers
152 involving any issues other than those two (2) specified in
153 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
154 the administrative hearing procedures established by the Division
155 of Medicaid.
156 (e) When a facility of a category that does not require
157 a certificate of need for construction and that could not be
158 eligible for Medicaid reimbursement is constructed to nursing
159 facility specifications for licensure and certification, and the
160 facility is subsequently converted to a nursing facility pursuant
161 to a certificate of need that authorizes conversion only and the
162 applicant for the certificate of need was assessed an application
163 review fee based on capital expenditures incurred in constructing
164 the facility, the division shall allow reimbursement for capital
165 expenditures necessary for construction of the facility that were
166 incurred within the twenty-four (24) consecutive calendar months
167 immediately preceding the date that the certificate of need
168 authorizing such conversion was issued, to the same extent that
169 reimbursement would be allowed for construction of a new nursing
170 facility pursuant to a certificate of need that authorizes such

171 construction. The reimbursement authorized in this subparagraph
172 (e) may be made only to facilities the construction of which was
173 completed after June 30, 1989. Before the division shall be
174 authorized to make the reimbursement authorized in this
175 subparagraph (e), the division first must have received approval
176 from the Health Care Financing Administration of the United States
177 Department of Health and Human Services of the change in the state
178 Medicaid plan providing for such reimbursement.
179 (5) Periodic screening and diagnostic services for
180 individuals under age twenty-one (21) years as are needed to
181 identify physical and mental defects and to provide health care
182 treatment and other measures designed to correct or ameliorate
183 defects and physical and mental illness and conditions discovered
184 by the screening services regardless of whether these services are
185 included in the state plan. The division may include in its
186 periodic screening and diagnostic program those discretionary
187 services authorized under the federal regulations adopted to
188 implement Title XIX of the federal Social Security Act, as
189 amended. The division, in obtaining physical therapy services,
190 occupational therapy services, and services for individuals with
191 speech, hearing and language disorders, may enter into a
192 cooperative agreement with the State Department of Education for
193 the provision of such services to handicapped students by public
194 school districts using state funds which are provided from the
195 appropriation to the Department of Education to obtain federal
196 matching funds through the division. The division, in obtaining
197 medical and psychological evaluations for children in the custody
198 of the State Department of Human Services may enter into a
199 cooperative agreement with the State Department of Human Services
200 for the provision of such services using state funds which are
201 provided from the appropriation to the Department of Human
202 Services to obtain federal matching funds through the division.
203 On July 1, 1993, all fees for periodic screening and
204 diagnostic services under this paragraph (5) shall be increased by

205 twenty-five percent (25%) of the reimbursement rate in effect on
206 June 30, 1993.
207 (6) Physician's services. On January 1, 1996, all fees for
208 physicians' services shall be reimbursed at seventy percent (70%)
209 of the rate established on January 1, 1994, under Medicare (Title
210 XVIII of the Social Security Act), as amended, and the division
211 may adjust the physicians' reimbursement schedule to reflect the
212 differences in relative value between Medicaid and Medicare.
213 (7) (a) Home health services for eligible persons, not to
214 exceed in cost the prevailing cost of nursing facility services,
215 not to exceed sixty (60) visits per year.
216 (b) Repealed.
217 (8) Emergency medical transportation services. On January
218 1, 1994, emergency medical transportation services shall be
219 reimbursed at seventy percent (70%) of the rate established under
220 Medicare (Title XVIII of the Social Security Act), as amended.
221 "Emergency medical transportation services" shall mean, but shall
222 not be limited to, the following services by a properly permitted
223 ambulance operated by a properly licensed provider in accordance
224 with the Emergency Medical Services Act of 1974 (Section 41-59-1
225 et seq.): (i) basic life support, (ii) advanced life support,
226 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
227 disposable supplies, (vii) similar services.
228 (9) Legend and other drugs as may be determined by the
229 division. The division may implement a program of prior approval
230 for drugs to the extent permitted by law. Payment by the division
231 for covered multiple source drugs shall be limited to the lower of
232 the upper limits established and published by the Health Care
233 Financing Administration (HCFA) plus a dispensing fee of Four
234 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
235 cost (EAC) as determined by the division plus a dispensing fee of
236 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
237 and customary charge to the general public. The division shall
238 allow five (5) prescriptions per month for noninstitutionalized

239 Medicaid recipients.

240 Payment for other covered drugs, other than multiple source
241 drugs with HCFA upper limits, shall not exceed the lower of the
242 estimated acquisition cost as determined by the division plus a
243 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
244 providers' usual and customary charge to the general public.

245 Payment for nonlegend or over-the-counter drugs covered on
246 the division's formulary shall be reimbursed at the lower of the
247 division's estimated shelf price or the providers' usual and
248 customary charge to the general public. No dispensing fee shall
249 be paid.

250 The division shall develop and implement a program of payment
251 for additional pharmacist services, with payment to be based on
252 demonstrated savings, but in no case shall the total payment
253 exceed twice the amount of the dispensing fee.

254 As used in this paragraph (9), "estimated acquisition cost"
255 means the division's best estimate of what price providers
256 generally are paying for a drug in the package size that providers
257 buy most frequently. Product selection shall be made in
258 compliance with existing state law; however, the division may
259 reimburse as if the prescription had been filled under the generic
260 name. The division may provide otherwise in the case of specified
261 drugs when the consensus of competent medical advice is that
262 trademarked drugs are substantially more effective.

263 (10) Dental care that is an adjunct to treatment of an acute
264 medical or surgical condition; services of oral surgeons and
265 dentists in connection with surgery related to the jaw or any
266 structure contiguous to the jaw or the reduction of any fracture
267 of the jaw or any facial bone; and emergency dental extractions
268 and treatment related thereto. On January 1, 1994, all fees for
269 dental care and surgery under authority of this paragraph (10)
270 shall be increased by twenty percent (20%) of the reimbursement
271 rate as provided in the Dental Services Provider Manual in effect
272 on December 31, 1993.

273 (11) Eyeglasses necessitated by reason of eye surgery, and
274 as prescribed by a physician skilled in diseases of the eye or an
275 optometrist, whichever the patient may select.
276 (12) Intermediate care facility services.
277 (a) The division shall make full payment to all
278 intermediate care facilities for the mentally retarded for each
279 day, not exceeding thirty-six (36) days per year, that a patient
280 is absent from the facility on home leave. However, before
281 payment may be made for more than eighteen (18) home leave days in
282 a year for a patient, the patient must have written authorization
283 from a physician stating that the patient is physically and
284 mentally able to be away from the facility on home leave. Such
285 authorization must be filed with the division before it will be
286 effective, and the authorization shall be effective for three (3)
287 months from the date it is received by the division, unless it is
288 revoked earlier by the physician because of a change in the
289 condition of the patient.
290 (b) All state-owned intermediate care facilities for
291 the mentally retarded shall be reimbursed on a full reasonable
292 cost basis.
293 (13) Family planning services, including drugs, supplies and
294 devices, when such services are under the supervision of a
295 physician.
296 (14) Clinic services. Such diagnostic, preventive,
297 therapeutic, rehabilitative or palliative services furnished to an
298 outpatient by or under the supervision of a physician or dentist
299 in a facility which is not a part of a hospital but which is
300 organized and operated to provide medical care to outpatients.
301 Clinic services shall include any services reimbursed as
302 outpatient hospital services which may be rendered in such a
303 facility, including those that become so after July 1, 1991. On
304 January 1, 1994, all fees for physicians' services reimbursed
305 under authority of this paragraph (14) shall be reimbursed at
306 seventy percent (70%) of the rate established on January 1, 1993,

307 under Medicare (Title XVIII of the Social Security Act), as
308 amended, or the amount that would have been paid under the
309 division's fee schedule that was in effect on December 31, 1993,
310 whichever is greater, and the division may adjust the physicians'
311 reimbursement schedule to reflect the differences in relative
312 value between Medicaid and Medicare. However, on January 1, 1994,
313 the division may increase any fee for physicians' services in the
314 division's fee schedule on December 31, 1993, that was greater
315 than seventy percent (70%) of the rate established under Medicare
316 by no more than ten percent (10%). On January 1, 1994, all fees
317 for dentists' services reimbursed under authority of this
318 paragraph (14) shall be increased by twenty percent (20%) of the
319 reimbursement rate as provided in the Dental Services Provider
320 Manual in effect on December 31, 1993.
321 (15) Home- and community-based services, as provided under
322 Title XIX of the federal Social Security Act, as amended, under
323 waivers, subject to the availability of funds specifically
324 appropriated therefor by the Legislature. Payment for such
325 services shall be limited to individuals who would be eligible for
326 and would otherwise require the level of care provided in a
327 nursing facility. The division shall certify case management
328 agencies to provide case management services and provide for home-
329 and community-based services for eligible individuals under this
330 paragraph. The home- and community-based services under this
331 paragraph and the activities performed by certified case
332 management agencies under this paragraph shall be funded using
333 state funds that are provided from the appropriation to the
334 Division of Medicaid and used to match federal funds under a
335 cooperative agreement between the division and the Department of
336 Human Services.
337 (16) Mental health services. Approved therapeutic and case
338 management services provided by (a) an approved regional mental
339 health/retardation center established under Sections 41-19-31
340 through 41-19-39, or by another community mental health service

341 provider meeting the requirements of the Department of Mental
342 Health to be an approved mental health/retardation center if
343 determined necessary by the Department of Mental Health, using
344 state funds which are provided from the appropriation to the State
345 Department of Mental Health and used to match federal funds under
346 a cooperative agreement between the division and the department,
347 or (b) a facility which is certified by the State Department of
348 Mental Health to provide therapeutic and case management services,
349 to be reimbursed on a fee for service basis. Any such services
350 provided by a facility described in paragraph (b) must have the
351 prior approval of the division to be reimbursable under this
352 section. After June 30, 1997, mental health services provided by
353 regional mental health/retardation centers established under
354 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
355 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
356 psychiatric residential treatment facilities as defined in Section
357 43-11-1, or by another community mental health service provider
358 meeting the requirements of the Department of Mental Health to be
359 an approved mental health/retardation center if determined
360 necessary by the Department of Mental Health, shall not be
361 included in or provided under any capitated managed care pilot
362 program provided for under paragraph (24) of this section.
363 (17) Durable medical equipment services and medical supplies
364 restricted to patients receiving home health services unless
365 waived on an individual basis by the division. The division shall
366 not expend more than Three Hundred Thousand Dollars ($300,000.00)
367 of state funds annually to pay for medical supplies authorized
368 under this paragraph.
369 (18) Notwithstanding any other provision of this section to
370 the contrary, the division shall make additional reimbursement to
371 hospitals which serve a disproportionate share of low-income
372 patients and which meet the federal requirements for such payments
373 as provided in Section 1923 of the federal Social Security Act and
374 any applicable regulations.

375 (19) (a) Perinatal risk management services. The division
376 shall promulgate regulations to be effective from and after
377 October 1, 1988, to establish a comprehensive perinatal system for
378 risk assessment of all pregnant and infant Medicaid recipients and
379 for management, education and follow-up for those who are
380 determined to be at risk. Services to be performed include case
381 management, nutrition assessment/counseling, psychosocial
382 assessment/counseling and health education. The division shall
383 set reimbursement rates for providers in conjunction with the
384 State Department of Health.

385 (b) Early intervention system services. The division
386 shall cooperate with the State Department of Health, acting as
387 lead agency, in the development and implementation of a statewide
388 system of delivery of early intervention services, pursuant to
389 Part H of the Individuals with Disabilities Education Act (IDEA).
390 The State Department of Health shall certify annually in writing
391 to the director of the division the dollar amount of state early
392 intervention funds available which shall be utilized as a
393 certified match for Medicaid matching funds. Those funds then
394 shall be used to provide expanded targeted case management
395 services for Medicaid eligible children with special needs who are
396 eligible for the state's early intervention system.
397 Qualifications for persons providing service coordination shall be
398 determined by the State Department of Health and the Division of
399 Medicaid.

400 (20) Home- and community-based services for physically
401 disabled approved services as allowed by a waiver from the U.S.
402 Department of Health and Human Services for home- and
403 community-based services for physically disabled people using
404 state funds which are provided from the appropriation to the State
405 Department of Rehabilitation Services and used to match federal
406 funds under a cooperative agreement between the division and the
407 department, provided that funds for these services are
408 specifically appropriated to the Department of Rehabilitation

409 Services.

410 (21) Nurse practitioner services. Services furnished by a
411 registered nurse who is licensed and certified by the Mississippi
412 Board of Nursing as a nurse practitioner including, but not
413 limited to, nurse anesthetists, nurse midwives, family nurse
414 practitioners, family planning nurse practitioners, pediatric
415 nurse practitioners, obstetrics-gynecology nurse practitioners and
416 neonatal nurse practitioners, under regulations adopted by the
417 division. Reimbursement for such services shall not exceed ninety
418 percent (90%) of the reimbursement rate for comparable services
419 rendered by a physician.

420 (22) Ambulatory services delivered in federally qualified
421 health centers and in clinics of the local health departments of
422 the State Department of Health for individuals eligible for
423 medical assistance under this article based on reasonable costs as
424 determined by the division.

425 (23) Inpatient psychiatric services. Inpatient psychiatric
426 services to be determined by the division for recipients under age
427 twenty-one (21) which are provided under the direction of a
428 physician in an inpatient program in a licensed acute care
429 psychiatric facility or in a licensed psychiatric residential
430 treatment facility, before the recipient reaches age twenty-one
431 (21) or, if the recipient was receiving the services immediately
432 before he reached age twenty-one (21), before the earlier of the
433 date he no longer requires the services or the date he reaches age
434 twenty-two (22), as provided by federal regulations. Recipients
435 shall be allowed forty-five (45) days per year of psychiatric
436 services provided in acute care psychiatric facilities, and shall
437 be allowed unlimited days of psychiatric services provided in
438 licensed psychiatric residential treatment facilities.

439 (24) Managed care services in a program to be developed by
440 the division by a public or private provider. Notwithstanding any
441 other provision in this article to the contrary, the division
442 shall establish rates of reimbursement to providers rendering care

443 and services authorized under this section, and may revise such
444 rates of reimbursement without amendment to this section by the
445 Legislature for the purpose of achieving effective and accessible
446 health services, and for responsible containment of costs. This
447 shall include, but not be limited to, one (1) module of capitated
448 managed care in a rural area, and one (1) module of capitated
449 managed care in an urban area.

450 (25) Birthing center services.

451 (26) Hospice care. As used in this paragraph, the term
452 "hospice care" means a coordinated program of active professional
453 medical attention within the home and outpatient and inpatient
454 care which treats the terminally ill patient and family as a unit,
455 employing a medically directed interdisciplinary team. The
456 program provides relief of severe pain or other physical symptoms
457 and supportive care to meet the special needs arising out of
458 physical, psychological, spiritual, social and economic stresses
459 which are experienced during the final stages of illness and
460 during dying and bereavement and meets the Medicare requirements
461 for participation as a hospice as provided in 42 CFR Part 418.

462 (27) Group health plan premiums and cost sharing if it is
463 cost effective as defined by the Secretary of Health and Human
464 Services.

465 (28) Other health insurance premiums which are cost
466 effective as defined by the Secretary of Health and Human
467 Services. Medicare eligible must have Medicare Part B before
468 other insurance premiums can be paid.

469 (29) The Division of Medicaid may apply for a waiver from
470 the Department of Health and Human Services for home- and
471 community-based services for developmentally disabled people using
472 state funds which are provided from the appropriation to the State
473 Department of Mental Health and used to match federal funds under
474 a cooperative agreement between the division and the department,
475 provided that funds for these services are specifically
476 appropriated to the Department of Mental Health.

477 (30) Pediatric skilled nursing services for eligible persons
478 under twenty-one (21) years of age.
479 (31) Targeted case management services for children with
480 special needs, under waivers from the U.S. Department of Health
481 and Human Services, using state funds that are provided from the
482 appropriation to the Mississippi Department of Human Services and
483 used to match federal funds under a cooperative agreement between
484 the division and the department.
485 (32) Care and services provided in Christian Science
486 Sanatoria operated by or listed and certified by The First Church
487 of Christ Scientist, Boston, Massachusetts, rendered in connection
488 with treatment by prayer or spiritual means to the extent that
489 such services are subject to reimbursement under Section 1903 of
490 the Social Security Act.
491 (33) Podiatrist services.
492 (34) Personal care services provided in a pilot program to
493 not more than forty (40) residents at a location or locations to
494 be determined by the division and delivered by individuals
495 qualified to provide such services, as allowed by waivers under
496 Title XIX of the Social Security Act, as amended. The division
497 shall not expend more than Three Hundred Thousand Dollars
498 ($300,000.00) annually to provide such personal care services.
499 The division shall develop recommendations for the effective
500 regulation of any facilities that would provide personal care
501 services which may become eligible for Medicaid reimbursement
502 under this section, and shall present such recommendations with
503 any proposed legislation to the 1996 Regular Session of the
504 Legislature on or before January 1, 1996.
505 (35) Services and activities authorized in Sections
506 43-27-101 and 43-27-103, using state funds that are provided from
507 the appropriation to the State Department of Human Services and
508 used to match federal funds under a cooperative agreement between
509 the division and the department.
510 (36) Nonemergency transportation services for

511 Medicaid-eligible persons, to be provided by the Department of
512 Human Services. The division may contract with additional
513 entities to administer nonemergency transportation services as it
514 deems necessary. All providers shall have a valid driver's
515 license, vehicle inspection sticker and a standard liability
516 insurance policy covering the vehicle.

517 (37) Targeted case management services for individuals with
518 chronic diseases, with expanded eligibility to cover services to
519 uninsured recipients, on a pilot program basis. This paragraph
520 (37) shall be contingent upon continued receipt of special funds
521 from the Health Care Financing Authority and private foundations
522 who have granted funds for planning these services. No funding
523 for these services shall be provided from State General Funds.

524 (38) Chiropractic services: a chiropractor's manual
525 manipulation of the spine to correct a subluxation, if x-ray
526 demonstrates that a subluxation exists and if the subluxation has
527 resulted in a neuromusculoskeletal condition for which
528 manipulation is appropriate treatment. Reimbursement for
529 chiropractic services shall not exceed Seven Hundred Dollars
530 ($700.00) per year per recipient.

531 (39) Services provided by the State Department of
532 Rehabilitation Services for the care and rehabilitation of persons
533 with spinal cord injuries or traumatic brain injuries, as allowed
534 under waivers from the U.S. Department of Health and Human
535 Services, using funds that are appropriated to the Department of
536 Rehabilitation Services from the Spinal Cord and Head Injury Trust
537 Fund established under Section 37-33-261 and used to match federal
538 funds under a cooperative agreement between the division and the
539 department.

540 Notwithstanding any provision of this article, except as
541 authorized in the following paragraph and in Section 43-13-139,
542 neither (a) the limitations on quantity or frequency of use of or
543 the fees or charges for any of the care or services available to
544 recipients under this section, nor (b) the payments or rates of

545 reimbursement to providers rendering care or services authorized
546 under this section to recipients, may be increased, decreased or
547 otherwise changed from the levels in effect on July 1, 1986,
548 unless such is authorized by an amendment to this section by the
549 Legislature. However, the restriction in this paragraph shall not
550 prevent the division from changing the payments or rates of
551 reimbursement to providers without an amendment to this section
552 whenever such changes are required by federal law or regulation,
553 or whenever such changes are necessary to correct administrative
554 errors or omissions in calculating such payments or rates of
555 reimbursement.

556 Notwithstanding any provision of this article, no new groups
557 or categories of recipients and new types of care and services may
558 be added without enabling legislation from the Mississippi
559 Legislature, except that the division may authorize such changes
560 without enabling legislation when such addition of recipients or
561 services is ordered by a court of proper authority. The director
562 shall keep the Governor advised on a timely basis of the funds
563 available for expenditure and the projected expenditures. In the
564 event current or projected expenditures can be reasonably
565 anticipated to exceed the amounts appropriated for any fiscal
566 year, the Governor, after consultation with the director, shall
567 discontinue any or all of the payment of the types of care and
568 services as provided herein which are deemed to be optional
569 services under Title XIX of the federal Social Security Act, as
570 amended, for any period necessary to not exceed appropriated
571 funds, and when necessary shall institute any other cost
572 containment measures on any program or programs authorized under
573 the article to the extent allowed under the federal law governing
574 such program or programs, it being the intent of the Legislature
575 that expenditures during any fiscal year shall not exceed the
576 amounts appropriated for such fiscal year.

577 SECTION 2. This act shall take effect and be in force from
578 and after July 1, 1999.